DOCUMENTATION REQUIRED UNDER SECTION 381.986, (4)(c) FLORIDA STATUTES, SUPPORTING THE DETERMINATION THAT THE SMOKING OF MEDICAL MARIJUANA IS AN APPROPRIATE ROUTE OF ADMINISTRATION

A qualified physician must submit the following documentation to the applicable board if the qualified physician determines that smoking is an appropriate route of administration for a qualified patient, other than a patient diagnosed with a terminal condition. Do not provide any patient identifying information other than what is requested in this form.

Send the completed form to: MQA.HCPR-DataTeam@flhealth.gov.
or
Mail to:

BOARD OF OSTEOPATHIC MEDICINE
4052 Bald Cypress Way Bin C-06
Tallahassee, FL 32399-1708

or

BOARD OF MEDICINE
4052 Bald Cypress Way Bin C-03
Tallahassee, FL 32399-1708

Qualified MD/DO License Number: ______________________ First part of the file name

Date physician certification issued: ______________________ Last part of the file name - will change with the next certification

Qualifying patient's year of birth: ______________________ Second part of the file name

Qualifying patient's ID Number: P______________________

1. The patient has tried other routes of administration: Yes No

If you answered yes, provide information that shows list of other routes of administration certified by a qualified physician that the patient has tried, the length of time the patient used such routes of administration, and an assessment of the effectiveness of those routes of administration in treating the qualified patient's qualifying condition. Attach additional sheets as necessary.

Route	Active Period (Start Date – End Date)	Assessment of Effectiveness
1. Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	
2. Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	
3. Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	

DRAFT

4. Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	
5. Inhalation, Oral, Sublingual, Suppository, or Topical	__/__/____ - __/__/____ MM/DD/YYYY MM/DD/YYYY	

2. Provide research documenting the effectiveness of smoking as a route of administration to treat similarly situated patients with the same qualifying condition as the qualified patient. Attach additional documentation if necessary.

DRAFT

3. As the qualified physician, it is my opinion that the benefits of smoking marijuana for medical use outweigh the risks for the qualified patient.

____

Signature of qualified physician **Date**